



Medical Report

Individual Underwriting Department
P.O. Box 9041
Oxnard, CA 93031-9041
Phone: (866) 297-7647
Fax: (805) 713-8829

Each person on the Individual Enrollment Application must submit a separate completed Medical Report.

Applicant Name _____

Medical History – This form must be completed in its entirety by a participating Blue Cross physician.

Date of Exam: _____ (must be within 12 months of application date)

Please check any of the following as they apply and provide dates, hospitalization, and other pertinent details in the space provided under "Explanation" below. You may also include copies of the patient's medical records.

- Heart Disease
- Pulmonary Disease
- Cancer
- Tuberculosis
- Diabetes Mellitus
- AIDS/ARC
- Seizure Disorder
- Alcohol Abuse
- Drug Abuse
- Participation in a drug or alcohol rehabilitation program
- Mental Illness
- Counseling
- Neurological Disorder
- Other injuries, surgeries or illnesses

Explanation: _____

Does this patient have any future surgery or hospitalization planned? Yes No If yes, please explain: _____

Is the patient currently on any medication(s)? Yes No If yes, indicate name, dosage and reason for medication(s): _____

Laboratory

List the following laboratory results or attach a copy of the lab report(s):

Cholesterol Date: _____ Results: TC _____ HDL _____ LDL _____

Triglycerides Date: _____ Results: _____

Blood sugar Date: _____ Results: _____

Hematocrit or Hemoglobin Only Date: _____ Results: _____

Serum Creatinine Date: _____ Results: _____

Physical Examination

Age	Height	Weight	Pulse	Respiration	BP
Please indicate (+) if abnormal or (-) if normal as they apply and provide details in space provided.					
HEENT	Hearing	Abdomen	Neurological	Heart	
Sight	Skin	GU	Lungs	OB/GYN	

Explanation of any abnormal findings: _____

Name of Attending Physician (Please Print)	Degree/Licensure		Telephone
Street Address	City	State	ZIP Code
Signature	Provider Number		Date